STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445469	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY HALL NURSING HOME	301 WATAUGA AVE ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	Disclaimer for Plan of Correction Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Ivy Hall Nursing Home of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Ivy Hall Nursing Home files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings. **F 225** Ivy Hall Nursing Home believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 3-28-14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on the facility's investigation reports and interviews, the facility had failed to report an alleged allegation of abuse in accordance with State law within five (5) working days of the incidimt for one resident, (#15), of thirty residents reviewed. The findings included: Resident #15 was admitted to the facility on November 28, 2012, with diagnoses including Encephalopathy, Dysphagia, Osteoporosis, Severe Anxiety, Hypertension, Altered Mental Status and Muscle Weakness. Interview with Resident #15 on March 11, 2014, at 11:06 a.m., in the resident's room, revealed the resident, "...saw a resident's hand slapped...happened shortly after I came...here a year this past November...reported...the person no longer here..." Interview with Resident#15 on March 12,2014, at 3:15p.m., in the resident's room, revealed the resident did not remember the staff member the incident was reported to, the time of the day of the incident, or the name of the staff member involved in the incident. Interview with the Abuse Coordinator, and the Administrator on March 13, 2014, at 11:22 a.m., in the Administrator's office, confirmed the facility did not report the alleged incident to the State Agency. The Administrator stated, "I take full responsibility for the decision to not report the incident."	F 225	surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Residents On 11/30/12, resident #15 had reported to the nurse administering resident #15's medications that resident #15 had observed a staff member "being rough" with resident #15's roommate. Resident #15 had been admitted only two days prior to this alleged incident for drug overdose at home, but stated that the staff member no longer worked there. According to Human Resources records, no employee was terminated or left facility employment during November or December of 2012. An investigation was initiated by the Social Services Director immediately on 11/30/12. Resident #15 was lethargic and confused at that time. Resident #15's recall of this incident changed many times along with the description of the staff member. The Director of Nursing also spoke with resident #15 on this date, but no clearer picture from resident's statements could be found. A summary of the investigation concluded that the allegation was not substantiated. On 3/13/14, the Administrator and Social Services Director reviewed the investigation with the state survey team.	

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F 226 F 226 SS=D	Continued From page 2 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of the facilty's Abuse Protocol policy, and interview, the facility had failed to follow their policy by not reporting an allegation of abuse in accordance with State law, within five (5) working days of the incident for one resident (#15), of thirty residents reviewed. The findings included: Resident #15 was admitted to the facility on November 28, 2012, with diagnoses including Encephalopathy, Dysphagia, Osteoporosis, Severe Anxiety, Hypertension, Altered Mental Status and Muscle Weakness. Interview with Resident #15 on March 11, 2014, at 11:06 a.m., in the resident's room, revealed the resident, "...saw a resident's hand slapped...happened shortly after I came...here a year this past November...reported...the person no longer here..." Interview with Resident #15 on March 12, 2014, at 3:15 p.m., in the resident's room, revealed the resident does not remember the staff member the incident was reported to, the time of the day of the incident, or the name of the staff member	F 226 F 226	**Monitoring** Allegations of abuse reported by residents/staff will be addressed by the Social Services Director during the daily Department Head Meeting. A monthly audit of the Comment/Concern Log will be reviewed by the Social Services Director to ensure allegations of abuse have been reported to the appropriate State Agency, per state law and per facility policy. The results of this audit will be presented by the Social Services Director to the monthly Performance Improvement Committee until the desired threshold has been met for three consecutive months; then quarterly. The Performance Committee consists of the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Business Office Manager, Maintenance Director, Dietary Manager, Housekeeping /Laundry Director, Activities Director, Medical Records Director, Human Resources Manager, MDS Coordinator, Medical Director, and Consultant Pharmacist. **F 226** Ivy Hall Nursing Home believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	4/20/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2014
FORM APPROVED
OMB NO. 0938-0391

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F 226	Continued From page 3 involved in the incident. Review of the facility's Abuse Protocol, effective March 1993 and last reviewed August 2012, revealed, "...The administrator will notify the following of any/all...reports...The appropriate State Health Department office...in accordance with specific state regulations and time frames..." Interview with the Abuse Coordinator and the Administrator, on March 13, 2014, at 11:22 a.m., in the Administrator's office, confirmed the facility did investigate, but did not report the alleged incident to the State Agency,and failed to follow their Abuse Policy. The Administrator stated, "I take full responsibility for the decision to not report the incident."	F 226	Director to ensure allegations of abuse have been reported to the appropriate State Agency, per state law and per facility policy. The results of this audit will be presented by the Social Services Director to the monthly Performance Improvement Committee until the desired threshold has been met for three consecutive months; then quarterly. The Performance Committee consists of the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Business Office Manager, Maintenance Director, Dietary Manager, Housekeeping /Laundry Director, Activities Director, Medical Records Director, Human Resource Manager, MDS Coordinator, Medical Director, and Consultant Pharmacist.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:	F 274	**F 274** Ivy Hall Nursing Home believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions: **Corrective Actions for Targeted Residents** A Significant Change Minimum Date Set Assessment was completed for Resident #82 on 3/26/14 by the MDS Coordinator.	4/20/14

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F 274	Continued From page 4 Based on observation, medical record review, and interview, the facility had failed to complete a Significant Change Minimum Data Set (MDS) in a timely fashion for one resident (#82), of thirty sampled residents. The findings included: Resident #82 was admitted to the facility on October 29, 2013, with diagnoses including Pnuemonia, Chronic Kidney Disease Stage 3, Difficulty Walking, Muscle Weakness, Dysphagia, Plueral Effusion, and Congestive Heart Failure. Observation of the resident on March 12, 2014, at 7:56 a.m., in the Main Dining Room, revealed the resident sitting in a wheelchair and being fed by staff. Observation of the resident on March 12, 2014, at 3:30 p.m., in the resident's room, revealed the resident laying in a low bed, with oxygen running by nasal canula. Continued observation and attempted interview of the resident, revealed the resident was oriented to person only, and was very confused. Observation of the resident on March 13, 2014, at 8:30 a.m., in the resident's room, revealed the resident laying in a low bed, talking and mumbling to self. Medical record review of a Discharge Assessment MDS dated January 27, 2014, revealed the resident scored a 12 on the Brief Interview for Mental Status (BIMS) indicating the resident was cognitively intact, required extensive assistance with all Activities of Daily Living (ADLs), required supervision with eating, and was	F 274	**Identification of Other Residents with Potential to be Affected** Residents experiencing a significant change in status have the potential to be affected by this practice. Residents who in the last 30 days have had a hospital stay, residents who have been picked up by Therapy Services, and residents who have had a mental or physical decline were reviewed on 3/13/14 by the MDS Coordinator to ensure a Significant Change of Status MDS Assessment is warranted. None were found to be appropriate for this assessment. **Systematic Changes** An in-service was conducted on 3/13/14 by the MDS Coordinator for nursing staff regarding the need to complete a Significant Change of Status MDS Assessment within 14 days of facility determining a resident has experienced a significant change in physical and/or mental status. This in-service will be repeated on 3/28/14 by the MDS Coordinator to ensure nursing staff is educated. Newly-hired nursing staff will be educated during their orientation period by the MDS Coordinator regarding the need to complete a Significant Change of Status MDS Assessment for residents experiencing a significant change in physical and/or mental status.	

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F 274	Continued From page 5 always continent of bladder. Medical record review of a psychiatric consult note dated February 4, 2014, revealed the resident was seen by the consultant psychiatrist "...nearly unresponsive today, a stark contrast to our session two weeks ago when (resident) indicated that...was looking forward to the homework I left (resident) (breathing excercises) ...per nurse note pt picking at (resident's) blanket stating (resident) is plucking chickens...also stated there was a cat under (resident's) bed..." Medical record review of a Physician Progress Note dated March 5, 2014, revealed the resident's oral medications were discontinued due to the resident's refusal, and spitting out the medications. Continued review revealed the resident was documented as "...poor prognosis..." Interview with the resident's physician on March 12, 2014, at 10:30 a.m., in the Assistant Director of Nursing's office, revealed the resident has had a severe decline in functional and cognitive status. Continued interview confirmed the resident's family had been contacted to consider hospice for the resident. Interview with the MDS Coordinator on March 13, 2014, at 9:10 a.m., in the MDS Coordinator's office, revealed the MDS Coordinator had not completed a significant change MDS. Continued interview revealed the MDS Coordinator had not completed the significant change MDS due to the MDS Coordinator did not believe the resident's functional status had changed in three areas or more. Interview with the MDS Coordinator on March 13,	F 274	**Monitoring** A monthly audit will be conducted by the MDS Coordinator to ensure a Significant Change of status MDS Assessment is completed within 14 days of facility determining a resident has experienced a significant change in physical and/or mental status. The results of this audit will be presented by the MDS Coordinator to the monthly Performance Improvement Committee until desired threshold is met for three consecutive months; then quarterly. The Performance Committee consists of the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Business Office Manager, Maintenance Director, Dietary Manager, Housekeeping /Laundry Director, Activities Director, Medical Records Director, Human Resource Manager, MDS Coordinator, Medical Director, and Consultant Pharmacist.	4/20/14

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F 274	Continued From page 6 2014, at 9:55 a.m., at the C-Wing Nurse Station, revealed the MDS Coordinator was not aware a significant change MDS was required for a resident with a decline in functional status in only one area of ADLs. Continued interview with the MDS Coordinator confirmed a significant change MDS should have been completed for the resident.	F 274		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	**F 441** Ivy Hall Nursing Home believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions: **Corrective Actions for Targeted Residents** Nurse #1 was counseled on 3/11/14 by the Director of Nursing regarding the need to wear gloves when administering medications through a PEG tube, per infection control protocol. Resident #54 has shown to ill effects from this practice. **Identification of Other Residents with Potential to be Affected** Residents receiving medications via a PEG tube have the potential to be affected by this practice. An observation audit of medication administration via a PEG tube was conducted by the Director of Nursing on 3/12/14. Nurses were found to be	

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	445469	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IVY HALL NURSING HOME	301 WATAUGA AVE ELIZABETHTON, TN 37643

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 7 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and interview, the facility had failed to maintain infection control protocol by not wearing gloves during medication administration for one resident, (#54), of six residents observed. The findings included: Observation on March 10, 2014, at 3:43 p.m., during medication pass on the A -200 hall revealed, Licensed Practical Nurse (LPN #1) accessed resident #54's gastrostomy tube (a surgically implanted tube in the abdomen for the administration of nutrition and medications into the stomach) administered medications through the tube, flushed the tube with water, and closed the tube access port, without wearing gloves. Review of the facility policy Medication Administration: Feeding Tube, effective February 1998, reviewed June 2013, revealed, "...Procedure...wash hands...put on gloves..." Interview with LPN #1, on March 10, 2014, at 3:50 p.m., outside the resident's room, confirmed LPN #1 had not worn gloves, gloves were to have been worn during the procedure, and the facility	F 441	compliant with infection control protocol by wearing gloves during administration of medications via a PEG tube on this date. **Systematic Changes** An in-service was held on 3/11/14 by the Director of Nursing and the Assistant Director of Nursing to educate licensed nurses of the need to wear gloves during medication administration via a PEG tube, per infection control protocol. This in-service will be repeated on 3/28/14 by the Director of Nursing to ensure licensed nurses are educated. Newly-hired nursing staff will be educated during their orientation period by the Director of Nursing regarding the need to wear gloves when administering medications via a PEG tube, per infection control protocol. **Monitoring** A weekly audit will be conducted by the Director of Nursing for four weeks to observe nurses administering medications via a PEG tube to ensure gloves are worn appropriately, per infection control protocol. This audit will then be conducted monthly by the Director of Nursing. The results of this audit will be presented by the Director of Nursing for review and recommendation until desired threshold is met for three consecutive months; then quarterly.	

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F 441	Continued From page 8 failed to maintain infection control protocol during the medication pass.	F 441	The Performance Committee consists of the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Business Office Manager, Maintenance Director, Dietary Manager, Housekeeping /Laundry Director, Activities Director, Medical Records Director, Human Resource Manager, MDS Coordinator, Medical Director, and Consultant Pharmacist.	4/20/14
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility policy, and interview, the facility had failed to complete behavioral management documents, pain flow sheets, and medication administration records for three of seven residents (#98, #46, #82) of thirty-six residents reviewed. The findings included: Resident (#98) was admitted to the facility on February 18, 2013, with diagnoses including Alzheimer's, Disease, Psychosis, Insomnia, and Anxiety. Review of the Quarterly Minimum Data Set dated December 8, 2013, revealed the resident was	F 514	**F 514** Ivy Hall Nursing Home believes its current practices were in compliance with the applicable standard of care, but that in order to respond to this citation from the surveyors, the facility is taking the following additional actions: **Corrective Actions for Targeted Residents** Resident #98's Behavioral Monthly Flow Records were completed and signed by licensed nurses on 3/14/14. Resident #46's Medication Administration Record and Psychoactive Medication Monthly Flow Records were signed by licensed nurses on 3/14/14. Resident #82's Medication Administration Records and Pain Flow Sheets were signed by licensed nurses on 3/14/14.	

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F 514	Continued From page 9 moderately cognitively impaired, and required assistance with activities of daily living. Medical record review of the Behavioral Monthly Flow Records for January 2014, and February 2014 , revealed "...pacing...pulling hair...monthly total...(blank)...nurses progress notes (blank)...nurse signature...(blank)..." Review of the facility policy Psychopharmacological Medications effective January 2000, reviewed September 2008 revealed, "...nursing will initiate the Behavior Monitoring Form...complete the appropriate sections every shift...total all columns at the end of each month..." Resident #46 was admitted to the facility on July 28, 2010, with diagnoses including Overactive Bladder, Difficulty in Walking, Anorexia, Vascular Dementia with Delusions, Psychosis, Depression, and Muscle Weakness. Medical record review of Medication Administration Records (MARS) for the months of February and March 2014, revealed nurse initials for each date a medication was administered. Continued review of the MARS revealed no nurse signature on the back of the MARS which identified the nurse who administered the medications. Medical record review of Psychoative Medication Monthly Flow records for the months of February and March 2014, revealed no nurse signatures on the records. Resident #82 was admitted to the facility on October 29, 2013, with diagnoses including	F 514	**Identification of Other Residents with Potential to be Affected** Current residents have a potential to be affected by this practice. Current MARs, TARs, Behavioral Sheets, and Pain Flow Sheets were signed by facility licensed staff on 3/14/14 and are to be completed by 3/31/14. **Systematic Changes** An in-service was held for licensed nurses on 3/14/14 by the Director of Nursing and Assistant Director of Nursing regarding the need to complete and sign the back of MARs, TARs, Pain Flow Sheets, and Behavioral Sheets if their initials appear on the front. This in-service will be repeated on 4/11/14 by the Director of Nursing and Assistant Director of Nursing to ensure nurses are educated. Newly-hired nursing staff will be educated during their orientation period by the Director of Nursing and Assistant Director of Nursing regarding the need to complete and sign MARs, TARs, Behavioral Sheets, and Pain Flow Sheets if their initials appear on the front. **Monitoring** A monthly audit will be conducted by the Director of Nursing to ensure that monthly MARs, TARs, Behavioral Sheets, and Pain Flow Sheets are completed and signed by nurses whose initials appear on	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	Continued From page 10 Pnuemonia, Chronic Kidney Disease Stage 3, Difficulty Walking, Muscle Weakness, Dysphagia, Plueral Effusion, and Congestive Heart Failure. Medical record review of Medication Administration Records (MARS) for the months of February and March 2014, revealed nurse initials for each date a medication was administered. Continued review of the MARS revealed no nurse signature on the back of the MARS which identified which nurse administered the medications. Medical record review of Pain Flow Sheets for the months of February and March 2014 revealed pain level documentation by nurses which were documented with a nurse's initials. Continued review of the Pain Flow Sheets revealed no documentation of which scale the nurses had utilized to document the resident's pain level. Further review of the Pain Flow Sheets revealed no nurse signatures on the flow sheets. Interview with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on March 13, 2014, at 4:49 p.m., in the ADON's office confirmed the forms were to have included the nurse signatures, and monthly totals. Continued interview confirmed the facility had failed to complete the forms.	F 514	the front. The results of this audit will be presented by the Director of Nursing to the monthly Performance Improvement Committee for review and recommendations until desired threshold is met for three consecutive months; then quarterly. The Performance Committee consists of the Administrator, Assistant Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Business Office Manager, Maintenance Director, Dietary Manager, Housekeeping /Laundry Director, Activities Director, Medical Records Director, Human Resource Manager, MDS Coordinator, Medical Director, and Consultant Pharmacist.	4/20/14